SPSO decision report

Case: **202001994, Lanarkshire NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their late parent (A) who died following surgery to remove cancerous tissue. C said that the care and treatment that A received in hospital was not reasonable, and that A's cancer should have been detected earlier. C believed there were failings in the management of A's care which caused A pain, distress and discomfort and this was worsened by the standard of nursing care.

We took independent advice from two appropriately qualified advisers. We found that the diagnosis concerning the spread of cancer was reasonable and did not uphold this aspect of C's complaint.

In relation to nursing care, we found that there was a lack of accurate and appropriate pressure assessments, and a lack of timely interventions led to the development of severe pressure damage. There was inappropriate wound management causing deterioration to wounds and poor observation of urinary output. We also found that the standard of record-keeping was unreasonable, that national pressure ulcer prevention standards and relevant policy were not followed and there was delay in referring to specialists. Therefore, we upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the standard of nursing care provide to A, for failing to carry out appropriate assessments to prevent severe pressure damage, failing to provide appropriate wound management, failing to appropriately monitor urine output, delaying referrals and failing to follow relevant standards and policy. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information -leaflets.

What we said should change to put things right in future:

- A wound chart should be completed for each wound detailing size, tissue type present, treatment and treatment objectives.
- Fluid balance charts should be completed to acceptable standard for early recognition of fluid balance issues.
- Pressure ulcer risk assessments should be calculated properly on admission and reassessments recorded at least weekly and when clinical condition changes.
- Sufficient information should be given to a patient and or their family to allow them to make an informed choice when deciding to decline pressure relieving interventions. This should be recorded in the case notes.
- Tissue viability referrals should be made in line with the relevant national guidance.

We have asked the organisation to provide us with evidence that they have implemented the recommendations

we have made on this case by the deadline we set.